

## Transmutation of The Reproductive Life of Women in Southern/West Cameroon(S) 1922-1972: A Colonial Manipulation

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### Abstract:

In all human communities, societal continuity depended on the quality and availability of infant and maternity welfare services. Conscious of the outcomes of infancy care on the productive efficiency of individuals at adulthood, the reproductive life of women and child welfare became an area of European domination during colonialism. Using British Southern/West Cameroon(s) as the theatre, this paper sets out to uncover colonial motives in the transformation of reproductive practices among women as it examines the different strategies and mechanisms employed in extending maternity and infant welfare as a measure of colonial imperialism. Archival information and oral interviews made up primary sources while books, published articles and dissertations constituted the secondary sources. The descriptive historical approach was employed in the analysis of the work. This paper submits that: the British colonial administration in Southern Cameroons had a mask colonial exploitative economic agenda behind the assignment put forth by the League of Nations Mandate Commission in its Article II of the British Mandate agreement. A baseless racial discrimination and cultural domination motivated the transformation of the reproductive life of indigenous women and the extension of basic infant welfare services during the Mandate and trusteeship periods in Southern Cameroons. These services were mostly provided by Western Mission agencies and plantation firms who recognized the independence of Southern Cameroons but withheld the rights to medical autonomy. In some cases, the transfer of rights to manage the medical arm of the different agencies was partially transferred during the last years of the Cameroon federation and in some cases after the abrogation of the Cameroon federation. The British decision to administer Southern Cameroons as a mandate was a conspiracy to enforce the tentacles of colonialism and its diverse arms with hope of greater economic and cultural gains.

**Keywords:** Transmutation, Reproduction, Women, Southern/West Cameroon(s), Midwifery

### Introduction:

In 1922, Britain was given the mandate by the League of Nations to administer Southern

Cameroons as a mandate 'B' territory.<sup>1</sup> This was in confirmation with the 1916 partition of the former German protectorate. According to article II of the mandate agreement, Britain was to ensure the

<sup>1</sup> Mandated territories were former German colonies given to the allied powers to be administered under the supervision of the League of Nations Mandate Commission. A 'B' mandate was a territory considered to be

economically unable to administer itself and therefore was said to need a more developed nation to aid it towards development.

social wellbeing of the population of the mandated territory. In line with this, the government through different colonial agencies (planters, missionaries, Native Authorities, and colonial government) put forth initiatives to transform the reproductive life of women. In an effort to provide for the welfare of infants and women during and after intra-uterine life, these agencies condemned traditional midwifery and described it as being laid on the foundation of barbarism and unhygienic practices<sup>2</sup>. It was also argued that the heavy loss of infant life was largely due to the faulty conduct of deliveries and the faulty treatment of the infants by native midwives and their mothers<sup>3</sup>. These assumptions on African midwifery prompted colonial agencies to seek ways of transforming the reproductive life of indigenous women. Though these initiatives were gloriously announced as intending to improve on welfare to affect infant and maternal mortality, I argue that, they had undeclared colonial intentions which were to have potential Christian converts, maintain a steady supply of labor, distract the population from colonial economic exploitation and limit violent resistances among others. The paper examines the approaches employed in transforming the reproductive life of women in an effort to achieve colonial objectives. The paper argues that the provision of western biomedical infant and maternity welfare services had a complex agenda and only benefited the indigenous women as much as they were needed for the attainment of these agendas.

Scholars have put forth diverse views regarding the intentions of colonial authorities' in the transformation of reproduction within their respective colonies. Callaway argues that

education to women during gestation and post natal welfare was a form of social emancipation which sought to create within indigenous women Western gender norms intended to mold 'suitable' wives for educated Christian men.<sup>4</sup> The education provided to women also sought to incorporate them into the society by making provisions for some women to access opportunities of gaining salaried jobs<sup>5</sup>. Mumford and Williamson in support of Callaway's view holds that domestic science classes opened up spaces for girls as they were given the opportunity to take up occupations outside of the home<sup>6</sup>. Contrary to the views of Callaway and Mumford, Adams holds that the gendered form of schooling served as avenues for colonial control and ideological tools through which European ideals and norms of hygiene and domesticity were transferred to indigenous women<sup>7</sup>. Fielding in line with Adams opines that the number of girls who got enrolled in the different vocational training centers over the years showed prove of the colonial administrations' intension in eradicating African norms and cultures like traditional midwifery, polygamy and bride wealth through Western education<sup>8</sup>.

Lang on his part looks at the economic benefits the colonial administration envisaged before introducing maternity and child welfare services. He holds that the exploitative colonial agenda of the colonizers were primordial in every action they put forth. Seeking to maintain a healthy work-force for colonial projects in the territory, infant and maternity welfare services were put in place to curb infant mortality and breathe healthy children.<sup>9</sup> Hunts in line with Lang opines that the fear of the outcome of depopulation on colonial projects

<sup>2</sup> Nana Amposah, "Colonizing the Womb, Women, Midwifery and the State of Colonial Ghana," (PhD Thesis in History, University of Texas Austin, 2011), 105

<sup>3</sup> NAB, File No. 1626, Annual Medical Reports, Southern Cameroons, 1954/1955.

<sup>4</sup> Helen Callaway, *Gender, Culture and Empire: European Women in Colonial Nigeria*, (London: Palgrave Macmillan, 1970), 20.

<sup>5</sup> Callaway, *Gender, Culture and Empire*, 20.

<sup>6</sup> Bryant Mumford and John Williamson, "Comparative colonial Education," *Review of Educational Research* 9, no 4, (1939): 397.

<sup>7</sup> Melinda Adams "Colonial Policies and Women's Participation in Public Life: the Case of British Southern Cameroons," *African Studies quarterly* 8, no 3, (2006): 4.

<sup>8</sup> Patience Fielding, "Gender Perspectives in Higher Education: Women in Science and Engineering in Cameroon," (PhD Thesis in Education, University of California, Berkeley, 2014), 5.

<sup>9</sup> Micheal Lang, "Colonial Child Survival Initiatives in Southern Cameroons: A challenging multi-Actor sector, 1922-1961," *Journal of history and culture* 9, (2019): 101-102.

necessitated the introduction of infant and maternity welfare services in colonial Africa.<sup>10</sup> Contrary to the views of Lang and Hunts, Morgan on her part argues that, the exportation of Western biomedicine especially child and mother welfare services were intended to civilize African women and combat the increasing death toll that existed in the colonies<sup>11</sup>. The transformation of the reproductive life of women in British Southern West Cameroon(s) had complex objectives ranging from the extension of Western ideologies and cultures to the production of healthy infants who were potential laborers. The British colonial administration in Southern Cameroons had economic interest and cultural domination as central motives in the transformation of the reproductive life of women. This colonial model was inherited at independence with little or no modifications. Actors such as planters and missionaries granted independence but withheld medical works until later during the Cameroon Federation and even beyond. These healthcare providers in achieving their objectives made strides in the sphere of prenatal care, birthing and post natal care.

### **Efforts in the Transformation of Reproduction in Southern Cameroons:**

In the 1930s, the British colonial administration realized her economic interest was threatened by the high infant and maternal mortality rates in the territory.<sup>12</sup> This provoked the British colonial administration in the territory to make strides towards the transformation of reproduction as she settled on a policy to improve the health of women as agents of procreation and infants as potential

work force.<sup>13</sup> The earliest efforts at transforming the reproductive life of women were realized by mission agencies in the territory. This was aided by the midwifery ordinance of 1931 which laid down the conditions for the practice of the profession of midwife in British Colonial Africa. Though having a special status, Southern Cameroons was administered as a province under British Nigeria. The high rates of infant mortality in Southern Cameroons in the 1930s were striking to the Mill Hill missionaries. This threatened their hope of gaining potential converts and hence on the 12<sup>th</sup> of October 1935, a medical team made up of five Mill Hill sisters arrived Cameroon from London. On the 16<sup>th</sup> of October 1935, the Mill Hill sisters (Franciscan Tertiary Sisters of Brixen) led by Sister Camilla Gaier were dispatched to Shisong in the Bamenda province of Southern Cameroons with the assignment of 'carrying out the medical, educational and social Apostolate'<sup>14</sup>. While at Shisong, they saw the need to address the sexual and reproductive needs of women. This urgent need with the hope of attaining more Christian converts led to the birth of the first maternity home in the territory on the 17<sup>th</sup> of November 1935<sup>15</sup>. This was followed by the creation of the Mbem maternity center in 1936<sup>16</sup> (by the North American Baptist), the Bafut Maternity center in 1938 by the Basel mission among others. This continued throughout the mandate period and during the trusteeship era, the colonial government, planters and Native Authorities joint the missionaries in the provision of infant and maternity welfare services to the indigenous population.

Though there existed government hospitals in the territory as early as 1922<sup>17</sup>, these hospitals did not

<sup>10</sup> Nancy Rose Hunts, *A Colonial Lexicon of Birth Rituals, Medicalization and Mobility in the Congo*, (Durham and London: Duke University Press, 1999), 3.

<sup>11</sup> Jennifer Morgan, "Some Could Suckle Over their Shoulders: Male Travellers, Female Bodies and the Gendering of Racial Ideologies, 1500-1770," *the William and Mary quarterly* 54, no 8, (1997): 173.

<sup>12</sup> NAB, sa/e (1933) 1, Cameroons under British Mandate: Measures for the Improvement of Conditions of Women.

<sup>13</sup> NAB, sa/e (1933) 1, Cameroons under British Mandate: Measures for the Improvement of Conditions of Women.

<sup>14</sup> Anthony Ndi, *Mill Hill Missionaries in Southern Cameroons-West Cameroon 1922-1972: Prime Partners in*

*Nation Building*. (Nairobi: Pauline Publications Africa, 2005), 97.

<sup>15</sup> Maureen Keng Musi, "Sickle Cell Disease in the Bamenda Plateau 1850-2013: Continuities and Discontinuities in the Control and Management," (MA Dissertation in History, University of Bamenda, 2018), 44.

<sup>16</sup> Agnes Ngwe, "Mbingo Baptist Hospital 1954-2004: An Assessment of Humanitarian-Driven Social Mission," (MA Dissertation in History, University of Bamenda, 2018), 46.

<sup>17</sup> Flavius Mokake, "Public Health and Public Health Management in British Southern Cameroons, 1922-1961: The Case of the Victoria Division," (MA Dissertation in History, University of Buea. 2011), 28-29.

take into account the reproductive life of indigenous women and hence there were no maternity centers in the hospitals before 1944. To Forkusam, “the government however argued without any attempt to open one for trial that, such services will not be beneficial to women folks who were so tied to their traditional systems of childcare (dependent on herbs, beliefs in the supernatural and the place of women as indigenous midwives) such that all foreign interference was rejected”<sup>18</sup>. These arguments were mainly imperial as mission agencies in the territory were capturing the attention of some women through their medical works. With the increased infant and maternal mortality due to the outbreak of the second world war, and pressure from the United Nations trusteeship Commission, as well as the introduction of the common wealth development and welfare funds, the British administering government through the Advisory Committee of the Development and Welfare Board considered infant and maternal welfare as part of healthcare in Southern Cameroons. The first initiative of this board towards infant and maternity welfare was the decision to institute the creation of maternity units in all government hospitals and Native Authority health units<sup>19</sup>. Though this decision was arrived at in 1944, it was immediately applied only to the victoria general hospital. This could have been due to the health and sanitary situation of plantation workers and their dependents in the division. In 1955, there were three Native Authority maternity centers, one government maternity center in Victoria, and nine mission maternity centers in the territory<sup>20</sup>.

It was not until 1959 that all general hospitals in the territory had maternity centers. It should be noted that these general hospitals were only found at divisional headquarters where colonial officials

were settled. Notwithstanding the slow progress in the development of maternity centers in the territory, by 1961, there were 5 government maternity centers, 17 Native Authority Maternity Centers, two Cameroon Development Corporation maternity centers and 12 mission maternity centers.<sup>21</sup> These facilities were meant to serve a female population of approximately 368.814 according to the 1953 population census.<sup>22</sup> By 1972, there were 38 Native Authority maternity centers, 13 mission centers, 3 plantation centers and 7 government maternity centers with 2 PMI centers (*Protection Maternelle et Infantile*) in West Cameroon<sup>23</sup>. The establishment of maternity centers in the different hospitals and health units were followed by the provision of preventive and curative healthcare services in the different centers. The wellbeing of women during pregnancy, childbirth and childcare were some key areas the colonizers paid attention to.

### **Transformation of pregnancy:**

With the putting in place of the different health structures in Southern Cameroons, staff and equipment were put in place to ensure the services at the units were functional. The main prenatal activity that was carried out in the different maternity centers was antenatal clinics during which expectant women were examined physically and biomedically by midwives, lessons on bathing, nutrition and the stages of labor were taught to these women. Delivery was also conducted in the different maternity centers. This was in an effort to transform and reconstruct birthing from the African way of using traditional birth attendants to hospitalized birthing under the care and supervision of midwives and medical doctors.<sup>24</sup> Antenatal clinics were the main services offered to expectant mothers in an effort to transform

<sup>18</sup> Austin Forkusam Langmia, “The Evolution of Health Services in the Southern Cameroons under British Administration 1916-19145”, (DES Dissertation in History, University of Yaounde I, 1977), 38.

<sup>19</sup> NAB, Sc (1944) 1, Advisory Committee on Economic and Social Welfare, Cameroon’s Provincial Committee, medical and health.

<sup>20</sup> NAB, Sc(1955)1, Annual Reports, Medical Department Southern Cameroon.

<sup>21</sup> NAB, Sc(1959)2, Annual Medical Reports.

<sup>22</sup> RAB, File No. NW/Sd.1962/1, Annual Medical Reports 1961.

<sup>23</sup> NAB, Sc(1959)2, Annual Medical Reports.

<sup>24</sup> Nancy Rose Hunts, *A Colonial Lexicon of Birth Rituals, Medicalization, and Mobility in the Congo*, (Durham and London: Duke University Press, 1999), 5.

reproduction. In this light, weekly, biweekly and monthly clinic visits were organized in the maternity centers and hospitals to manage pregnancy. This was based on flawed and pejorative connotations that women across communities in Southern Cameroons did not have the required knowledge and skills in the management of pregnancy and its related complications. Information on the need to attend antenatal clinics in the different hospitals and maternity centers came through sensitizations and advocacy in churches, during antenatal clinics and other public occasions. Midwives, missionary sisters, sanitary inspectors and other medical staffs made domiciliary visits to pregnant women and encouraged them on the need to attend antenatal clinics<sup>25</sup>. During these antenatal clinics, the three key activities were biomedical examinations, educative talks on hygiene/health and nutrition of the fetus during intra uterine life and the mother.

With regards to biomedical examinations, expectant mothers during every antenatal clinic had their systolic blood pressure estimated to check for the presence of preeclampsia<sup>26</sup>. There was a physical examination of the breast during every first antenatal clinic. There were physical examinations to detect cases of oedema<sup>27</sup> of the face and legs. A pelvic examination to assess the adequacy of the pelvic cavity and pelvic outlet was done to ascertain the possibility of normal vaginal birthing. Complicated cases were sent to bigger health facilities for surgical operations to ensure the safety of the mother and child at birth<sup>28</sup>.

Aside from biomedical examinations, patients attended educative lessons on hygiene and general health during antenatal clinics. During antenatal clinics lesson on hygiene and general health

included the following: expectant mothers were schooled on lessons such as diet during pregnancy, what to eat during the different trimesters of pregnancy and the quantities that were necessary. These lessons over time gradually influenced the perception of women regarding indigenous midwifery and its practice. Some women through these welfare services were cajole and coerced to embrace Christianity. Western ways of feeding began finding expression in the territory to the detriment of indigenous dishes that were of high and natural nutritional values and also served as medicine to the women during gestation.<sup>29</sup> These pregnant women were also taught the need to carry out physical exercises during pregnancy<sup>30</sup>. Pregnant women were advised not to carry out tedious activities such as excessive farming and the carrying of heavy luggage over long distances. This influenced the activities of women and further increased antipathy among women who still upheld some of their cultural belief systems. Breast care was also part of the lessons on general hygiene and health.<sup>31</sup>.

Added to biomedical examinations and general hygiene, lessons on nutrition during pregnancy were dispensed to expectant mothers. The different sources of nutrients, minerals and vitamins needed during the three trimesters of pregnancy were taught during clinics. Though the greater proportion of welfare services offered during antenatal clinics were preventive as seen above, there were some curative healthcare services provided to expectant mothers. Anti-malaria prophylaxes were given to women during antenatal clinics to prevent the women and the fetus from

<sup>25</sup>Bisherine Bongaatoh Kiven, "Christian Mission Agencies and Mother and Child Welfare Services in British Southern Cameroon: 1922-1961", (MA Dissertation in History, University of Bamenda, 2019), 51-52.

<sup>26</sup> The medical personnel that were in charge of these examinations were Western midwives and laboratory technicians. African trained midwives and laboratory technicians mostly served observational duties and in some cases served as auxiliaries during these biomedical processes. They were often seen as being unapt.

<sup>27</sup>Oedema is a buildup of fluids in parts of the body which causes the affected tissues to become swollen. In pregnancy, it's mostly the legs, hands and face that get swollen.

<sup>28</sup> NAB, Sc/a/1967/6, Teaching Guide IWC and ANC.

<sup>29,29</sup> Helen Ndenoh, (farmer), in Discussion with the Author, 25<sup>th</sup> February 2024.

<sup>30</sup> Ida Maria Dah Steger (Retired Midwife) in Discussion with the Author, 17<sup>th</sup> April 2024.

<sup>31</sup> Margaret Neh Mbahdeh (Indigene of Bafut), in Discussion with the Author, 10<sup>th</sup> May 2023.

contracting the malaria parasite<sup>32</sup>. Minor ailments in pregnancy such as malaria were treated in the different maternity centers. Quinine in a low dose was administered to pregnant women who were diagnosed of malaria<sup>33</sup>. Iron tablets and folic acid were equally provided to the women to boost their blood levels and ensure healthy babies were born with little malformations such as rickets and clubfoot.<sup>34</sup> These curative welfare services were the most resisted. Some women who were administered drugs to be consumed home took them and ended up not consuming. Some consumed with fear and others believed these drugs distant them from their gods and cultures. The introductions of indigenous auxiliary staff in the maternities gradually build confidence in the women.

Plantation, Missionary and Native Authority midwives went beyond the maternity centers into communities with mobile clinics during which preventive antenatal care was dispensed to women who lived in enclave communities where access to biomedical care was not available. During these mobile clinics, women who were encountered with complicated cases were moved to the health units with the aid of Land Rovers, ambulances and bicycles<sup>35</sup>. Women in labor were delivered by these midwives and they were encouraged to visit the different health units for post natal services to ensure healthy babies.

Traditional midwives and sanitary inspectors were schooled on some basic aspects of Western midwifery all in an effort to ensure the Western model of care was highly propagated and practiced in the territory.<sup>36</sup> In Communities like Mbem, indigenous midwives were identified by the Baptist mission and placed at the maternity. During their placements, they were trained on Western methods of childcare for an average duration of one year.

After their training, they were sent to their communities and some of them were recruited to serve in the Native Authority maternity centers. Trained sanitary inspectors from Nigeria had the responsibility of controlling the level hygiene that was practiced in the communities. Some of their sanitary inspectors were extracted by mission agencies and given basic lessons on midwifery. During their field activities, these inspectors assisted in the duties of midwives in enclave communities.<sup>37</sup> These trainings were mostly offered as a means of promoting the practice of western infant welfare services with the hope of attaining the colonial agenda.

According to Bih Helen an informant from Bafut, there were other curative healthcare services for pregnant women that necessitated the attention of the medical doctor. Sharing her experience, she observed that

When I had my first pregnancy, the Nsem health center just came. My mother told me not to go there for fear that they will take me to the coast. I had bleeding for long and finally the child did not survive. The next pregnancy came and this time I went to the hospital because of bleeding. Sister Mary of the Nsem Basel maternity tried everything but it did not work. I was sent to Belo where the big doctor confined me there until the child was born. I was given medications three times daily and we had a place where we even coked our food behind.<sup>38</sup>

Some common complications that necessitated medical attention and confinement were placenta previa (this is when the placenta covers the opening into the cervix), preeclampsia (hypertension in pregnancy), and profound bleeding in pregnancy. In most cases, expectant mothers were confined mostly in hospitals where doctors were stationed<sup>39</sup>.

<sup>32</sup>Egbe Philip, (Medical Doctor), in Discussion with the Author, 08<sup>th</sup> July 2023.

<sup>33</sup> Christina Ateh (Indigene of Bafut) in discussion with Author, 9<sup>th</sup> May 2023.

<sup>34</sup> Tasah Salome (Retired Midwife) in Discussion with the Author, 19<sup>th</sup> April 2024.

<sup>35</sup> Salome Tasah (Retired Midwife) in Discussion with the Author, 19<sup>th</sup> April 2024.

<sup>36</sup> Ida Maria Dah Steger (Retired Midwife) in Discussion with the Author, 17<sup>th</sup> April 2024.

<sup>37</sup> Ida Maria Dah Steger (Retired Midwife) in Discussion with the Author, 17<sup>th</sup> April 2024.

<sup>38</sup> Helen Bih, (Indigene of Bafut), in discussion with Author on 9<sup>th</sup> May 2023.

<sup>39</sup>Nsahtim Elizabeth kacha, (Indigene of Nwa), In Discussion with the Author, 18<sup>th</sup> June 2023.

As the number of expectant mothers who visited the different maternity centers over the years increased, the need to transform the practice of midwifery and childbirth from the home to the

hospital became unavoidable (see table I). All these efforts were intended to present the superiority in the western culture and ensure a steady supply of labor to European project sites for economic gains.

**Table I: Antenatal clinic Attendance in British Cameroons from 1944 to 1972**

| Years<br>Centers          | 1944 | 1954 | 1956 | 1959 | 1963   | 1965  | 1972    |
|---------------------------|------|------|------|------|--------|-------|---------|
| CBM Mbem                  | 16   | 37   | 487  | 391  | 446    | 550   | 765     |
| CBM Banso                 | 215  | 399  | 1300 | 1657 | 5941   | 8500  | 12000   |
| CBM Belo                  |      |      | 704  | 576  | 720    | 4695  | 6453    |
| RCM Shisong               | 322  | 459  | 892  | 1297 | 5133   | 1192  | 2203    |
| RCM Njinikom              |      | 212  | 736  | 586  | 2680   | 2019  | 2210    |
| BM Bafut                  |      |      | 614  | 4183 | 5941   | 1528  | 3544    |
| BM Nyasosso               |      |      | 748  | 415  | 1288   | 1251  | 1347    |
| General hospital victoria | 109  | 231  | 797  | 2922 | 3594   | 5096  | 6120    |
| General Hospital Bamenda  |      |      | 699  | 4703 | 8,541  | 2573  | 3534    |
| GeneralHospital Mamfe     |      |      | 340  | 1896 | 3266   | 1147  | 1432    |
| GeneralHospital Wum       |      |      |      | 2230 | 2775   | 2965  | 3456    |
| GeneralHospital Kumba     |      |      | 332  | 4946 | 1140   | 8247  | 1045    |
| GeneralHospital Nkambe    |      |      |      |      | 1397   | 2224  | 2349    |
| NA Centers                |      | 477  | 1364 | 1425 | 25,878 | 29356 | 35, 474 |
| PAMOL                     |      |      |      |      |        | 1224  | 2345    |
| CDC                       |      |      |      |      |        | 1200  | 1379    |

Source: NAB, Sc(1964)15, Medical Annual Reports on West Cameroon 1964-1971, NAB, Sc(1953)2, Medical and Sanitary Reports, NAB,Sc(1941)5, Medical and Sanitary Reports, NAB, SC(1959)2, Annual Medical Reports, NAB, Sc(1955)1, Annual Reports Medical Department Southern Cameroons, Annual Reports of the Cameroon Development Corporation for the year 1950

Legend: CBM-Cameroon Baptist Mission, RCM-Roman Catholic Mission, BN-Basel Mission, CDC- Cameroon Development Cooperation, NA-Native Authority.

Table 1 indicates progress in the attendance of antenatal clinics. As the years passed by, the number of pregnant women who attended western maternity centers increased. This increase led to the progressive transformation of the birthing style in British Cameroon. By 1972 when the Federal Republic of Cameroon became the United Republic of Cameroon, there were more women compared to the early years after the Second World War. This was probably because of the increase in the number of hospitals in the state, population increase and improved communication networks. As the number of maternity centers increased, some hospitals that were highly attended witnessed

a drop in attendance. This was because women who travelled long distances to get to hospitals had rural council health units in their localities that attended to their maternity needs. There were also other sensitization techniques (radio programs) that aided in the wide spread of information on the need to use medicalize birthing facilities<sup>40</sup>. Programs such as 'You and Your Health' and 'Radio Doctor' that were broadcasted twice every week on Radio Buea sensitized women on the need to exploit maternity services and this gradually transformed the reproductive life of indigenous women in the present Northwest and Southwest Regions of Cameroon. These programs emphasized the importance of Western biomedical infant and maternity welfare services and painted the weaknesses of indigenous midwives. Through these programs, women were coerced to visit and exploit the services provided in these maternities.

### **Transformation of Birthing**

The varied efforts in the supposed reconstruction of pregnancy through preventive and curative welfare services during antenatal clinics in maternity centers as seen above caused the different actors in the field of welfare service provision to see the need to stream their welfare services towards birthing. This desire was fueled by the alarming rates of infant and maternal mortality which were approximated at about 257 deaths per thousand births in 1939. These alarming rates of infant and maternal mortality were blamed on traditional midwives for gross medical malpractices and ignorance<sup>41</sup>. These traditional midwives were also accused of unhygienic practices (delivery babies without gloves, generating heating for the baby from firewood kitchens) that placed mothers and their new born babies at the mercy of avoidable infections and diseases that caused them their lives in some cases. Expectedly, there was recourse to a policy intended to medicalize birthing and so replaced the indigenous midwifery practice with

western biomedical midwifery. Contrary to the claim of unhygienic midwives, Ida Maria a Swiss Basel Mission midwife recounts her experiences serving in Bafut when she Say "we worked in Bafut for many years without gloves. The only difference was that we were 'clean' because we had our cooks, cleaners and gardeners who did every other work for us. We were focused only with our vocation".<sup>42</sup>

The move towards the hospitalization of birthing was further prompted by researches into the clinical causes of maternal deaths recommending the need for the utilization of certain obstetric techniques that were only suitable to be used in a hospital rather than in a home environment. Health officials argued that these obstetric techniques could not be adopted for the home environment because of the lack of proper sanitation and specifically designed spaces in the home.<sup>43</sup> Therefore, the hospital was the only appropriate place for delivery. One need not dig deeper to realize that this view was based solely on complicated labor cases and not on the numerous deliveries that had taken place in the milieu of the home. In many of the medical reports, the following were listed as causes of maternal deaths in the territory: Ante-Partum Hemorrhage, Premature Labor, Post-Partum Hemorrhage, Obstructed Labor, Obstetrical Shock, Puerperal Fever, Puerperal Septicemia, Eclampsia, Toxemia of Pregnancy, and Anemia of Pregnancy<sup>44</sup>.

The aforementioned justified the hospitalization of birthing in British Southern/West Cameroon(s) as the different actors made strides in varied dimensions in relieving the discomfort that came with child birth. In doing this, specialized units (labor/delivery rooms) were created in all maternity centers in which women were delivered of their babies. These units had delivery beds, waiting rooms, baby's cots, sterilizing agents, plastic gloves, weighing balances, lamps, surgical

<sup>40</sup> NAB, Sc(1964)11, Health Education.

<sup>41</sup> Bongaatoh, "Christain Mission Agencies", 54.

<sup>42</sup> Ida Maria Dah Steger (Retired Midwife) in Discussion with the Author, 17<sup>th</sup> April 2024.

<sup>43</sup> Amposah, "Colonizing the Womb, Women, Midwifery and the State Of Colonial Ghana, 120.

<sup>44</sup> Nana Amposah, "Colonizing the Womb, Women, Midwifery and the State Of Colonial Ghana", (PhD Thesis, University Of Texas Austin, 2011), 150



blades, and maternity clothes among other equipment<sup>45</sup>. During contractions, midwives regularly carried out vacuum checks on the expectant mother to ascertain the progress of labor. Injections to activate and increase contractions were given to some women who had difficult labor. This was to quicken the progress of contractions and shorten the length of labor to ensure the baby and mother were delivered in a good state that could ensure survival.

Though all these processes sought to have a healthy population and more Christian converts, the transformation of birthing among women was a gradual process as there was a high level of antipathy among indigenous women regarding maternity deliveries. Evidential increases were witnessed during the dyeing years of colonialism and after independence. This was partly due to an increase in the number of facilities, population growth and improved communication network (see Table II).

**Table II: Trends of Hospital Birthing in British Cameroons from 1944 to 1972**

| Years<br>Centers         | 1944 | 1954 | 1956 | 1959 | 1963 | 1965 | 1972 |
|--------------------------|------|------|------|------|------|------|------|
| CBM Mbem                 | 02   | 87   | 176  | 108  | 135  | 176  | 207  |
| CBM Bansa                | 87   | 136  | 543  | 1070 | 380  | 1552 | 1745 |
| CBM Belo                 |      |      | 394  | 397  | 641  | 870  | 1243 |
| RCM Shisong              | 322  | 328  | 678  | 810  | 710  | 845  | 987  |
| RCM Njinikom             |      | 230  | 342  | 395  | 387  | 357  | 1689 |
| BM Bafut                 |      | 154  | 247  | 293  | 422  | 385  | 1765 |
| BM Nyasosso              |      | 109  | 165  | 203  | 303  | 358  | 765  |
| Generalhospital victoria | 64   | 81   | 179  | 441  | 588  | 882  | 1400 |
| GeneralHospital Bamenda  |      |      | 366  | 477  | 789  | 442  | 657  |
| GeneralHospital Mamfe    |      |      | 117  | 270  | 379  | 169  | 346  |
| GeneralHospital Wum      |      |      |      | 148  | 294  | 456  | 680  |
| GeneralHospital Kumba    |      |      | 97   | 628  | 689  | 1137 | 2356 |
| GeneralHospital Nkambe   |      |      |      |      | 146  | 219  | 467  |
| NA Centers               |      | 229  | 315  | 1264 | 4730 | 5432 | /    |
| PAMOL                    |      |      |      |      | 137  | 342  | 654  |
| CDC                      |      | 240  | 360  |      | 101  | 380  | 786  |

<sup>45</sup>Raheal Asoh, (Retired Grade II Midwife Nsem Maternity), in Discussion with the Author, 12<sup>th</sup> May 2023.

Source: NAB, Sc(1964)15, Medical Annual Reports on West Cameroon 1964-1971, NAB, Sc(1953)2, Medical and Sanitary Reports, NAB,Sc(1941)5, Medical and Sanitary Reports, NAB, SC(1959)2, Annual Medical Reports, NAB, Sc(1955)1, Annual Reports Medical Department Southern Cameroons, Annual Reports of the Cameroon Development Corporation for the year 1950.

Legend: CBM-Cameroon Baptist Mission, RCM-Roman Catholic Mission, BN-Basel Mission, CDC- Cameroon Development Corporation, NA-Native Authority.

Table II above indicates there was a progressive trend in the transformation of reproduction among women in British Cameroon. The number of women who either accepted or were compelled/cajoled to use the services of trained birth attendants in the territory steadily increased as the year's progress. The increase in population, increase means of communication, increase in the number of maternity centers in the territory and intensive sensitization were contributing factors to the upward trend in the transformation of the reproductive life of women. Though the transfer of child birthing from the home to the hospital witnessed an upward trend during British rule and the years of the Cameroon federation, there was an indication of a level of antipathy among indigenous women regarding birthing in maternities/hospitals. This antipathy caused the colonizers to build up other mechanisms to transform the reproductive life of indigenous women including infant welfare clinics, domestic science centers and baby shows.

### **Transformation of child and maternal care**

To justify western transformation of child/maternal care from the home based and humanism approach that preceded European intrusion, colonialists argued that there was a definite relationship

between wrongful feeding of infants and childhood diseases. The Southern Cameroonian mothers' practice of carrying their babies on their backs all the time or letting them crawl about in the compound, from the colonial perspective, contributed to poor health in infants, and therefore, necessitated the reconstruction of African motherhood.<sup>46</sup> The most potent factors given for the high mortality and morbidity were ineffective and faulty mothering skills, poor nutrition, bad housing, and the bad methods of traditional midwives. The latter was particularly blamed for umbilical hernia that frequently occurred in newborn infants. Medical reports in the territory pointed to the fact that health officials justified the frequency of umbilical hernia among infants as generally being caused by ignorant treatment by 'native midwives', such as leaving the cord too long (the custom was to leave it long enough to reach the baby's knee). However, it was admitted that a certain proportion of babies born at the hospital and maternity centers also had umbilical hernia just as the babies delivered at home by traditional midwives<sup>47</sup>.

To purge Cameroonian mothers' maternal "ignorance" and to reengineer a new motherhood fashioned on the colonizers' ideals, colonial officials fell on one tool: maternal education. The reason was that out of ignorance, Cameroonian mothers exposed their infants to diseases; therefore, maternal education was the most appropriate tool to rectify the situation<sup>48</sup>. All mothers could be ignorant, but colonial officials believed that African women because of the excess time they spent working on the farm and in other domestic duties were particularly careless and neglectful of their children. Therefore, mothers were to be educated on their responsibility of maintaining personal hygiene and controlling filth in their domestic space<sup>49</sup>. The education dispensed to women was basically on hygiene and sanitation,

<sup>46</sup> Helen Callaway, Helen Callaway, *Gender, Culture and Empire: European Women in Colonial Nigeria*, (London: Palgrave Macmillan, 1987), 25.

<sup>47</sup> Ejogha, Nkwam, Florence. "British Medical and Health Policies in West Africa, 1920-1960," (PhD Thesis in

History, School of Oriental and African Studies, London University, 1988), 6.

<sup>48</sup> Egbe Philip Egbe Ngu, (Medical Doctor), in Discussion with the Author, 08<sup>th</sup> July 2023.

<sup>49</sup> Amposah "colonizing the womb," 112.

proper nutrition, bathing (mother and baby), clothing, vaccination of babies, organization of health weeks, and environmental sanitation<sup>50</sup>.

Judging from the statement of a famous British colonial official General Frederick G. Guggisberg of the Gold Coast who observed that “Once a nation has emerged from the primitive phases of its existence, education with all that it comprises becomes not only the first, but the only step towards progress”, it is no doubt the introduction of maternity education became part of the agenda of the colonial administration in the territories particularly Southern Cameroons<sup>51</sup>. In achieving this objective, Infant Welfare Centers were created within the different maternity units. At these welfare centers, women were expected to bring their children for routine monthly visits. During these routine visits, the trained midwives and sanitary officials dispensed educational talks to the mothers. These talks were intended to reorient women on child and maternal care in an effort to curb the high rates of infant and maternal mortality that prevailed in the territory.

In order to achieve the objective of educating Southern Cameroonian women, healthcare and welfare providers involved in the provision of maternal and infant welfare conceived that education in infant management could be channeled through either the mother or the daughter<sup>52</sup>. The education given to the mothers was done during infant welfare clinics. During these clinic sessions, mothers were educated on the techniques of bathing the baby. Women were also educated on the nutrition of both the infant and mother. After these educative lessons were given to the women, the babies were then weighed and their arm circumference measured to ensure the baby was growing and developing properly<sup>53</sup>. In cases where the weight and arm circumference of the baby

indicated malnutrition, the mother was educated on proper nutrition and in such cases, the midwives and sanitary inspectors made regular visits to the homes of these women as a means of ensuring the baby was properly cared for to ensure its survival<sup>54</sup>. Basic food needs such as blended wheat, rice, millet, soya and oil were provided for infants especially those with malnutrition. This was done during infant welfare clinics and community outreaches<sup>55</sup>. This was to boost the immune system of the infants and ensure post natal survival. The central motive of the colonizers remained getting a steady population that constantly supplied manual labor at colonial project sites for economic gains.

The healthcare providers, in an effort to ensure progress in their mission of transforming reproduction in the territory, introduced domiciliary visits. During these unannounced visits, midwives, sanitary inspectors and sometimes missionaries and their wives visited lactating mothers to monitor their level of care and hygiene during post natal life. Medical teams also moved to some areas where hospitals did not exist to carryout medical campaigns during which medical examinations were carried out on women and infants to ensure they were healthy. During these campaigns, sensitizations and advocacy were done to alert the women in rural communities of the availability of these services. All these efforts over the years yielded fruits as the number of women who turned out for infant welfare clinics steadily increased. For example in 1954, attendance of infant welfare clinics at the victoria general hospital stood at 592 and by 1959, it had increased to 1262<sup>56</sup>. The case was not different with the native Authority maternities and mission maternities in the territory. In 1955, the attendance of infant welfare clinics at the different Native Authority maternity centers stood at 983<sup>57</sup>. By

<sup>50</sup> Bongaatoh, “Christian Mission Agencies,” 60.

<sup>51</sup> Amposah “Colonizing the Womb,” 113.

<sup>52</sup> Amposah “Colonizing the Womb,” 114.

<sup>53</sup> Fombe Justine, (National Supervisor of Maternity and Child Health of the CBC), in Discussion with the Author, 04<sup>th</sup> August 2023.

<sup>54</sup> Fombe Justine, (National Supervisor of Maternity and Child Health of the CBC), in Discussion with the Author, 04<sup>th</sup> August 2023.

<sup>55</sup> Mafain Dorothy, (Midwife Mbingo Baptist Hospital), in Discussion with the Author, 21<sup>st</sup> August 2023.

<sup>56</sup> NAB, SC/a(1953)2, Medical and sanitary Reports.

<sup>57</sup> NAB, Sc(1955)1, Annual Reports, Medical department-Southern Cameroons

1961, the number of recorded infant welfare clinic attendance at Native Authority maternity centers had increased to 16,423<sup>58</sup>.

Aside from education during Infant Welfare Clinics, girl schools were designed to teach hygiene, cooking, home craft, home economics, and mother craft. This was because colonial educators believed girls would eventually end up as wives and as mothers. A government report on girls' education in schools indicated that the curriculum for girl education in girl schools involved female pupils undergoing a special course of training in domestic science (needlework, cookery, laundry, housewifery, child welfare, and hygiene).<sup>59</sup> The involvement of missionary wives in the process of educating women on home management was an indication of the desire of the colonizers to prepare and transform the hearts of the women to embrace Christian norms that could avoid in part resistance to the recruitment of their husbands and sons for the colonial labor force.

### Conclusion:

The transmutation of the reproductive life of women in British Southern/West Cameroon(s) was a gradual process that targeted all aspects of reproduction. The institution of antenatal clinics, hospitalization of birthing and education of lactating mothers on child and maternal care during post natal and post-partum life were the different initiatives put in place by the colonial healthcare providers to transform reproduction. From inception, these services were not overtly welcomed by indigenous women. As time progressed, different techniques were employed to cajole or compel the population to access and put to use Western welfare services and this increased the number of women who opted for Western welfare services. At independence, the colonial model of infant and maternity welfare service provision was adopted without any consideration for the culture, belief and real needs of the population. Though these services met some of the health needs of the population, it was a means through which the colonial authorities achieved

their economic agenda and promoted a colonial mentality among the women in the territory that was sustained over years even after colonial rule. By presenting Western ideals and cultures to Africans particularly Southern/West Cameroonians, the colonizers had the intension of undermining the African culture and imposing Western cultures with the hope of exploiting the ignorance of the locals for their economic gains.

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